Federal Fiscal Year 2001
FRAMEWORK FOR ANNUAL REPORT
OF STATE CHILDREN'S HEALTH INSURANCE PLANS
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

Preamble
Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist states in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with states to develop a framework for the Title XXI annual reports.

The framework is designed to:

- Recognize the ***diversity*** of State approaches to SCHIP and allow States ***flexibility*** to highlight key accomplishments and progress of their SCHIP programs, **AND**
- Provide ***consistency*** across States in the structure, content, and format of the report, **AND**
- Build on data ***already collected*** by CMS quarterly enrollment and expenditure reports, **AND**
- Enhance ***accessibility*** of information to stakeholders on the achievements under Title XXI.

Federal Fiscal Year 2001
FRAMEWORK FOR ANNUAL REPORT
OF STATE CHILDREN'S HEALTH INSURANCE PLANS
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

State/Territory: State of Washington

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

_____
(Signature of Agency Head)

SCHIP Program Name(s): Children's Health Insurance Program (CHIP)

SCHIP Program Type:
____ Medicaid SCHIP Expansion Only
__X__ Separate SCHIP Program Only
_____ Combination of the above

Reporting Period: Federal Fiscal Year 2001 (10/1/2000-9/30/2001)

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(Due to your CMS Regional Contact and Central Office Project Officer by January 1, 2002)
Please cc Cynthia Pernice at NASHP (cpernice@nashp.org)

SECTION 1. DESCRIPTION OF PROGRAM CHANGES AND PROGRESS

This sections has been designed to allow you to report on your SCHIP program changes and progress during Federal fiscal year 2001 (September 30, 2000 to October 1, 2001).

1.1 Please explain changes your State has made in your SCHIP program since September 30, 2000 in the following areas and explain the reason(s) the changes were implemented.

Note: If no new policies or procedures have been implemented since September 30, 2000, please enter "NC" for no change. If you explored the possibility of changing/implementing a new or different policy or procedure but did not, please explain the reason(s) for that decision as well.

A. Program eligibility NC

B. Enrollment process
We no longer require families to select a managed care plan at the time of enrollment into CHIP. Families may choose a managed care plan after they are enrolled.

C. Presumptive eligibility NC

D. Continuous eligibility NC

E. Outreach/marketing campaigns
Please refer to Section 2.4 for details regarding outreach changes.

F. Eligibility determination process
We eliminated the requirement for families to sign a written agreement to pay premiums as a condition of eligibility.

G. Eligibility redetermination process NC

H. Benefit structure NC

I. Cost-sharing policies NC

J. Crowd-out policies NC

K. Delivery system NC

L. Coordination with other programs (especially private insurance and Medicaid) NC

M. Screen and enroll process NC

N. Application NC

O. Other
We now allow SCHIP premiums to be paid in advance rather than allowing payment only on a monthly basis.

1.2 Please report how much progress has been made during FFY 2001 in reducing the number of uncovered low-income children.

A. Please report the changes that have occurred to the number or rate of uninsured, low-income children in your State during FFY 2001. Describe the data source and method used to derive this information.

Based on the Office of Financial Management's 2000 Washington State Population Survey (WSPS), it is estimated that there were 1,619,478 children 0-18 years of age of all income levels living in Washington State. It is estimated that 115,779 (7.1%) of these children did not have health insurance.

In the 1998 WSPS (conducted biennially), there were 1,609,589 children of all income levels. Of these, 124,939 (7.8%) were uninsured. This shows a decrease of 0.7 percentage points in the number of uninsured children over the two-year survey period. This is a 7.3% decrease in the number of uninsured.

The Table shown below details the population of insured and uninsured children of all income levels.

Survey Year	Total # of Children **(All Income Levels)**	Total # Insured	Total # Uninsured	Total % Uninsured	Percentage Point Change in Uninsured from Previous Survey
1998	1,609,589	1,484,650	124,939	7.8%	NA
2000	1,619,478	1,503,699	115,779	7.1%	-0.7

For all low-income children within both Medicaid and SCHIP income levels

(0-250% FPL), the percentage of children without health insurance decreased from 12.7% in the 1998 WSPS to 12.0% in the 2000 WSPS. This shows a decrease of 0.7 percentage points in the number of uninsured low-income children over the two-year survey period. This is a 15.6% decrease in the number of uninsured.

The Table below details the population of insured and uninsured in low-income households (0-250% FPL).

Survey Year	Total # of Children **(0-250% FPL)**	Total # Insured	Total # Uninsured	Total % of Uninsured	Percentage Point Change in Uninsured from Previous Survey
1998	676,696	590,776	85,920	12.7%	NA
2000	607,769	535,293	72,476	12%	-0.7

Of the 137,592 children whose household income level falls within SCHIP income levels (200-250% FPL), there were 7,456 children (5.4%) estimated to be uninsured at the time of the 2000 WSPS. In the 1998 WSPS, it was estimated that 14,300 children (8.2%) out of 174,820 SCHIP eligible children were uninsured. This shows a decrease of 2.8 percentage points over a two-year period in the number of SCHIP eligible children who are without insurance. This is a 48% decrease in the number of uninsured.

The Table below details the population of insured and uninsured children within SCHIP income levels (200-250% FPL).

Survey Year	Total # of Children **(200-250% FPL)**	Total # Insured	Total # Uninsured	Total % of Uninsured	Percentage Point Change in Uninsured from Previous Survey
1998	174,820	160,520	14,300	8.2%	NA
2000	137,592	130,136	7,456	5.4%	-2.8

For Medicaid eligible children (0-199% FPL), there were 501,876 children in the 1998 WSPS. Of this total, 71,585 (14.3%) were uninsured, and 430,291 (85.7%) had insurance. In the year

2000, there were 470,232 children between 0-199% FPL. The number of uninsured children dropped to 65,021 (13.8%). The number of children with insurance totaled 405,211 (86.2%). This is a decrease of 12.8% in the number of uninsured children in the two-year survey period.

The Table below details the population of insured and uninsured children within Medicaid income levels (0-199% FPL).

Survey Year	Total # of Medicaid Eligible Children **(0-199% FPL)**	Total # Insured	Total # Uninsured	Total % Uninsured	Percentage Point Change from Previous Survey
1998	501,876	430,291	71,585	14.3%	NA
2000	470,232	405,211	65,021	13.8%	-0.5

Washington has used its biennial Washington State Population Survey (WSPS) to make its baseline estimates. We will continue to use this source to measure subsequent changes in the number and percentage of children who have insurance coverage over time. The WSPS is a comprehensive survey conducted under contract with Washington State University's Social and Economic Sciences Research Center. The survey is modeled after U.S. Bureau of the Census's Current Population Survey (CPS). However, the survey is a statewide survey with a greatly enhanced sample size to allow for statistically reliable analyses for the state and regions within the state. There are expanded samples of racial and ethnic minorities to be able to compare socioeconomic characteristics of people of different racial and ethnic backgrounds. Since the WSPS is conducted biennially, the SCHIP uninsured performance measures will be reported every two years.

B. How many children have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information.

On September 30, 2000, there were 502,676 children in all program categories. As of September 30, 2001, we had 541,805 children in all program categories. This is an increase of 39,129 children, or 7.8%. Both Medicaid and SCHIP children are included in this total. This data comes directly from our Medicaid Management Information System (MMIS).

We do not have a direct count of the effects of the different types of outreach on the number of children enrolled in Medicaid and SCHIP. However, the number of children currently enrolled shows our state's commitment to outreach efforts.

We also continue to have assistance from the Healthy Kids Now! (HKN!) public awareness campaign that was launched in February 2000 along with the formal SCHIP launch. The HKN! campaign is aimed at families who are eligible for all the state's children's programs. They work closely with and directly support existing outreach activities. From October 2000 through September 2001, HKN! took in a total of 14,714 calls from families requesting information on children's programs. HKN! does not determine eligibility, but provides the caller with an initial screening to determine the likelihood of eligibility. They then refer or transfer the caller to a local outreach center, or send them an application.

Washington's medical applications are used to determine eligibility for both Medicaid and SCHIP. Our outreach contractors and advocates have found that many families apply for SCHIP believing their income is too high to qualify for Medicaid. Once applicable deductions are taken from gross income, it is often determined that the children qualify for Medicaid. Though we do not have data from our outreach contractors and advocates on frequency, we believe this has contributed to the increased enrollment in Medicaid eligible children.

C. Please present any other evidence of progress toward reducing the number of uninsured, low-income children in your State.

As noted in our state plan, Washington State will report on the number of SCHIP enrolled children on an annual basis. As of September 30, 2001, we have a total of 5,177 SCHIP children. This is an increase of 2,515 children over the past year.

D. Has your State changed its baseline of uncovered, low-income children from the number reported in your March 2000 Evaluation?

__X__ No, skip to 1.3

____ Yes, what is the new baseline?

What are the data source(s) and methodology used to make this estimate?

What was the justification for adopting a different methodology?

What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

Had your state not changed its baseline, how much progress would have been made in reducing the number of low-income, uninsured children?

1.3 Complete Table 1.3 to show what progress has been made during FFY 2001 toward achieving your State's strategic objectives and performance goals (as specified in your State Plan).

In Table 1.3, summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: List your State's strategic objectives for your SCHIP program, as specified in your State Plan.
Column 2: List the performance goals for each strategic objective.
Column 3: For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator and denominator). Please attach additional narrative if necessary.

Note: *If no new data are available or no new studies have been conducted since what was reported in the March 2000 Evaluation, please complete columns 1 and 2 and enter "NC" (for no change) in column 3*.

Table 1.3 (1) Strategic Objectives (as specified in Title XXI State Plan and listed in Your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
Objectives related to Reducing the Number of Uninsured Children		
To reduce the percentage of uninsured children between 200% and 250% FPL.	Reduce the percentage of uninsured children between 200% and 250% of FPL.	Data Sources: Washington State Population Survey (WSPS). Methodology: Tracking the percentage of uninsured children between 200% and 250% FPL. Progress Summary: Of children between 200% and 250% FPL, there were 8.2% who were uninsured in 1998. In 2000, the percentage decreased to 5.4%, meeting our goal of reducing the percentage of uninsured children.
Objectives Related to SCHIP Enrollment		

Table 1.3 (1) Strategic Objectives (as specified in Title XXI State Plan and listed in Your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
To increase the number of children in households between 200% and 250% of FPL who have health insurance coverage	Increase the number of children between 200% and 250% who have health care coverage. Reduce the percentage of uninsured children between 200% and 250% of FPL.	Data Sources: Washington State Population Survey (WSPS). Methodology: Tracking the number of children in households between 200% and 250% FPL with health insurance coverage. Progress Summary: In 1998, the estimated number of children between 200% and 250% FPL without health insurance was 14,300 (8.2%). In 2000, the estimated number without health insurance was 7,456 (5.4%). This shows that the percentage of children without health insurance has decreased by 2.8%, which meets our goal.
Objectives Related to Increasing Medicaid Enrollment		
To increase the number of low-income children in households below 200% of the FPL who have health insurance coverage.	Increase the number of children below 200% FPL, who have health coverage. Increase the percentage of children below 200% FPL who have health coverage.	Data Sources: Washington State Population Survey (WSPS). Methodology: Tracking the number of children with health insurance in households below 200% FPL. Progress Summary: In 1998, the estimated number of children in households below 200% FPL with health insurance was 430,291 (85.7%). In 2000, the number of children with health insurance was 405,211 (86.2%). This shows an increase of 0.5% in the percentage of insured children.
Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need)		
		Data Sources: Methodology: Progress Summary:
Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)		
	Track the satisfaction and health care of SCHIP children compared to Medicaid children and non-Medicaid children.	Data Sources: NC Methodology: Progress Summary:
Other Objectives		
		Data Sources:

Table 1.3 (1) Strategic Objectives (as specified in Title XXI State Plan and listed in Your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
		Methodology: Progress Summary:

1.4 If any performance goals have not been met, indicate the barriers or constraints to meeting them.

The assessment of SCHIP enrollees' satisfaction with their health care and services will be based on MAA's work with the Consumer Assessment of Health Plans (CAHPS). The annual CAHPS surveys are conducted in accordance with CAHPS Consortium (a group of national survey experts associated with the Harvard Medical School, RAND, and the Research Triangle Institute) protocols. A full sampling of SCHIP clients will be included in the 2002 CAHPS survey. The results will be available for our next annual report.

1.5 Discuss your State's progress in addressing any specific issues that your state agreed to assess in your State plan that are not included as strategic objectives.

In our State Plan we agreed to assess the effects of premiums on participation and the effects of cost- sharing on utilization. We anticipate we will have data available for the next annual report.

1.6 Discuss future performance measurement activities, including a projection of when additional data are likely to be available.

We expect to have CAHPS data by fall of 2002. At that time we will closely review the data and compare the findings with the Strategic Objectives and Performance Goals we set. Our findings will be reported in the next annual report.

1.7 Please attach any studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program's performance. Please list attachments here.

Please see Attachment A - HKN! Methodology Report

SECTION 2. AREAS OF SPECIAL INTEREST

This section has been designed to allow you to address topics of current interest to stakeholders, including; states, federal officials, and child advocates.

2.1 Family coverage:

A. If your State offers family coverage, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other program(s). Include in the narrative information about eligibility, enrollment and redetermination, cost sharing and crowd-out.

The state of Washington does not offer family coverage through Title XXI.

B. How many children and adults were ever enrolled in your SCHIP family coverage program during FFY 2001 (10/1/00 - 9/30/01)?

NA Number of adults
NA Number of children

C. How do you monitor cost-effectiveness of family coverage?

NA

2.2 Employer-sponsored insurance buy-in:

A. If your State has a buy-in program, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other SCHIP program(s).

The state of Washington does not offer employer-sponsored insurance buy-in.

B. How many children and adults were ever enrolled in your SCHIP ESI buy-in program during FFY 2001?

NA Number of adults
NA Number of children

2.3 Crowd-out:

A. How do you define crowd-out in your SCHIP program?

There are two general types of individual crowd-out. A family with employer-sponsored coverage or with other private coverage could elect to drop that coverage and enroll in a publicly subsidized program. Crowd-out could also occur over time as previously

uninsured families who enrolled in public programs elect to remain in those programs when offered employer-sponsored coverage.

In addition to individual crowd-out, there can be crowd-out effects by employers or the private market. Employers with a substantial share of low-wage workers could decide, through bargaining with their workers, to pay their employees higher cash wages instead of having dependent health insurance as part of the compensation package. In this case, the employee saves not only his direct premium payment for dependent coverage, but also receives higher cash wages.

B. How do you monitor and measure whether crowd-out is occurring?

Crowd-out is monitored through the eligibility determination process and through data collection. In our application process for SCHIP, we ask whether the child had employer-sponsored health insurance within the last four months. If the answer is yes, we ask them whether they have any exemptions that apply (see list of exemptions in Section 5.1, Table 5.1). If they do not have an exemption that applies, we require a four-month waiting period. The waiting period begins the day after employer-sponsored coverage ended.

C. What have been the results of your analyses? Please summarize and attach any available reports or other documentation.

Medical Assistance eligibility staff enter application information into a database as they process SCHIP applications. Data collected from applications during October 2000 through September 2001 showed that approximately 8.0% had dropped employer-sponsored insurance during the prior four months and would be subject to the four-month waiting period. The table below summarizes this data. Non-entered fields as well as data fields for "No Entry" and "Blank" relate to applications that were held for additional information.

Decision Date	Total Applications	Dropped Employer-Sponsored Insurance within last 4 months	Did not drop Employer-Sponsored Insurance	No Entry	Blank
Oct 2000	283	20	204	1	3
Nov 2000	274	19	186	5	2
Dec 2000	207	13	151	1	5

Jan 2001	312	19	206	1	7
Feb 2001	256	18	186	2	4
March 2001	314	22	234		4
April 2001	354	32	235	1	9
May 2001	361	32	222	7	12
June 2001	128	15	87	2	3
July 2001	277	33	154	12	4
Aug 2001	220	18	143	1	30
Sept 2001	171	11	77	1	56
TOTAL	3157	252	2085	34	139

D. Which anti-crowd-out policies have been most effective in discouraging the substitution of public coverage for private coverage in your SCHIP program? Describe the data source and method used to derive this information.

Our four-month waiting period that is implemented through the eligibility determination process appears to be successful. To ensure crowd-out is not occurring, if we do not have insurance information available on the initial submission of an application, we send a letter to the household requesting this information. If the request is not responded to, we do not approve enrollment as we are unable to determine eligibility for the program.

2.4 Outreach:

A. What activities have you found most effective in reaching low-income, uninsured children? How have you measured effectiveness?

Outreach Activities

The following information on outreach activities is based on the Medicaid outreach project and the Healthy Kids Now! (HKN!) public information campaign. Both of these activities target Medicaid and SCHIP children. Children must be assessed for Medicaid eligibility as a condition of determining SCHIP eligibility.

Background

In 1998, the Washington State Legislature authorized Medical Assistance Administration (MAA) to spend up to $3.9 million in enhanced funds for outreach to Medicaid eligibles. This project started in October 1998 and ended in June 2001. In July 2001, we began using SCHIP funding to support new outreach contracts. This funding will end in September 2002. The HKN! campaign began in February 2000, when SCHIP was launched in the State, and continues to support Medicaid and SCHIP outreach efforts through statewide activities, facilitating community efforts, and the statewide toll-free line, 1-877-KIDS NOW.

Contracts

The state of Washington continued its support of the HKN! public information campaign as well as community-based organizations by contracting with 35 organizations, covering 36 of 39 counties. Contractors include health districts, county social service departments and eight Indian tribes. We required contractors to submit applications that had to be approved before proceeding. After signing contracts, we provided local training to project staff on outreach strategies, eligibility criteria, and enrollment process. The State is reimbursing contractors by paying a monthly set rate and paying a $20 incentive for each client a contractor helps enroll. The community contracts were scheduled to end March 31, 2000 when the authorizing federal legislation sunsetted. However, in November 1999, Congress lifted the sunset date, so we were able to extend the outreach contracts until June 30, 2001, or until the enhanced federal funds were spent.

With the depletion in June 2001 of the $3.9 million in enhanced federal matching funds, contractors needed to come up with a higher match rate to contract for the available SCHIP outreach dollars beginning in July 2001. We now have 25 contracts that cover 33 of Washington's counties. Counties that do not have an outreach contractor can call the HKN! toll-free line or their local Community Services Office (CSO) for assistance.

Community-based contractors are required to:

- Identify people likely to be eligible for Medicaid coverage;
- Educate potential eligibles on the benefits of participating in the Medicaid program and eligibility requirements;
- Assist potential eligibles with completing an application for Medicaid eligibility;
- Educate new Medicaid clients on how to access services;
- Assist new Medicaid clients with selecting a Healthy Options health care plan that will best meet their needs; and
- Initiate follow-up with potential eligibles.

B. Have any of the outreach activities been more successful in reaching certain populations (e.g., minorities, immigrants, and children living in rural areas)? How have you measured effectiveness?

We have been successful at addressing three special audiences in our media campaigns: Hispanic/Latino, American Indian/Alaska Native (AI/AN), and children living in rural areas. To do this, we used radio to reach both Spanish-speaking audiences and residents in Southwest Washington counties not served by Washington's television stations. Rack cards were inserted in primarily rural newspapers statewide. Spanish rack cards were inserted in Latino publications and an advertisement was designed specifically for use in Tribal publications. Interior transit bulkhead ads (displayed behind the driver seat on the bus) were purchased in areas that showed strong ridership numbers and allowed advertising. Rack cards were available in these advertisements. Spanish and English rack cards were available in the Yakima area which has a large Hispanic/Latino population.

Direct mail lists were purchased and rack cards were mailed in underserved areas of the state targeting household income and households with children. We participated in a statewide child profile mailing, and bill stuffers were included in local public utility district bills in Southwest Washington.

In addition to TV, radio, newspaper ads and inserts, and transit bulkheads, an information kit was sent to all Tribes and Catholic churches.

Our rack cards and posters are printed in seven languages, including Spanish, Vietnamese, Russian, Cambodian, Korean and Chinese. The application is also printed in seven languages as well as other languages as the need arises.

C. Which methods best reached which populations? How have you measured effectiveness?

Front-line feedback from outreach projects, advocates, and partners was invaluable in making campaign adjustments and in planning tactics throughout the period of this report. Television spots continue to generate the most calls to the HKN! toll-free number, 1-877-KIDS NOW. Media relations were the second best tactic, especially creating feature stories with local news outlets. Direct mail strategies were also successful.

Statewide and community outreach efforts included a variety of strategies to maximize outreach efforts by:

- Increasing collaboration with community partners/advocates;
- Training partners in screening for children's medical applications;
- Extending use of bilingual/bicultural staff at application sites in communities;
- Partnering with ethnic community based organizations who use trusted advocates; and
- Continuing a state-wide multi-media campaign (fine-tuned all of the elements in use as well as testing new methods, i.e., direct mail, to achieve as much broad coverage as possible).

Another strategy by HKN! was to improve coordination and media education with the local outreach projects by:

- Developing a periodic newsletter to update outreach projects on campaign news and highlight tips/techniques that projects are finding successful.
- Repeating last year's survey to measure success and identify issues.
- Increasing local event coordination (local projects can access travel display, t-shirts, collateral and stickers for events in their communities).
- Completing a HKN! website that contains helpful information, including the new statewide update of the enrollment field guide and an accompanying training video.

- Disseminating collateral distribution tips and media relations tips and tools.
- Sending copies of public service announcements to all local outreach projects.

Capping all of these efforts, in June of this year the HKN! campaign won the prestigious Best of Silver Anvil Award awarded by the Public Relations Society of America. The campaign was chosen from among more than 700 national competitors, including campaigns from Nike, Sears, and Turner Broadcasting. The Silver Anvil, which symbolized the forging of public opinion, is awarded annually to public relations practitioners who address contemporary issues with exemplary professional skill, creativity and resourcefulness. The campaign is also being featured in a communications textbook written by an American University professor. This textbook is used in over 100 universities nationally and internationally.

2.5 Retention:

A. What steps are your State taking to ensure that eligible children stay enrolled in Medicaid and SCHIP?

Once enrolled, a child remains eligible for twelve consecutive months, regardless of income changes. At the tenth month of enrollment, the client is sent an eligibility review form to complete and return so that eligibility for another twelve months can be redetermined before the current twelve month period expires.

If a household falls behind in their premium payments, we notify them with a mailed notice once their premium payments have become both 90 and 120 days overdue. The 90-day notice lets them know they are behind in their payment and gives them a toll-free phone number to call to report if their income has changed or if there are other circumstances they need to report. At 120 days overdue, they receive a notice that tells them they will be disenrolled at the end of the current (or next month, depending on mailing date) if they do not pay. This notice also gives them a toll-free number to call.

Please see Attachments B and C – 90 and 120-day letters to clients

Also, a survey will be mailed in October 2001 to all households who have disenrolled since SCHIP's inception in February 2000. The survey will then be sent out to newly disenrolled households every six months. We anticipate the data from this survey will help provide answers as to why households have disenrolled. With the analysis of the data, we will be able to develop strategies to help resolve any barriers that may cause children to become disenrolled.

Please see Attachment D – Disenrolled Client Survey

B. What special measures are being taken to reenroll children in SCHIP who disenroll, but are still eligible?

___ Follow-up by caseworkers/outreach workers
___ Renewal reminder notices to all families
___ Targeted mailing to selected populations, specify population
___ Information campaigns
___ Simplification of re-enrollment process, please describe
__X__ Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, please describe:

A survey was developed and will be mailed in October 2001 to all households who disenrolled from SCHIP during their twelve months of certification as well as those who disenrolled at the end of the twelve-month eligibility period. Surveys will be sent every 6 months to newly disenrolled households following the initial survey. Survey results will be available for our next annual report.

___ Other, please explain

C. Are the same measures being used in Medicaid as well? If not, please describe the differences.

Children enrolled in Medicaid also receive an eligibility review form before their 12 months of eligibility ends. The review must be completed and returned so that another 12 months of eligibility may be determined.

D. Which measures have you found to be most effective at ensuring that eligible children stay enrolled?

We will be collecting and analyzing data from our fall 2001 surveys to determine what methods may be effective for SCHIP children. This data will be available for our next annual report.

E. What do you know about insurance coverage of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured?) Describe the data source and method used to derive this information.

We are working with our Automated Client Eligibility System (ACES) to develop a report that will detail the number of children who disenroll from SCHIP and consequently enroll in Medicaid. We anticipate data from this report will be available for our next annual report.

As noted in Section 2.5 A. and Section 2.5 B. we also developed a survey that will be mailed in October 2001 to all households that have disenrolled from SCHIP since SCHIP's inception in February 2000. After the initial mailing, the survey will be sent to newly disenrolled households every six months. The survey contains questions on insurance coverage. Data from this survey will be available in our next annual report.

2.6 Coordination between SCHIP and Medicaid:

A. Do you use common application and redetermination procedures (e.g., the same verification and interview requirements) for Medicaid and SCHIP? Please explain.

The state of Washington uses two standardized application forms to make eligibility determinations. One form is for clients applying for children's medical benefits. The other form is for clients applying for cash benefits, food stamps, medical coverage and other benefits. Potential SCHIP eligibles can apply for medical coverage by using either form. Both forms will be processed centrally through our Medical Eligibility Determination Services (MEDS) section or by the local Community Services Offices (CSOs).

As part of the process to determine SCHIP eligibility, information must be collected that is not needed to determine eligibility for other medical programs. For example, as part of the SCHIP eligibility process, families must

- Indicate whether a child has creditable insurance at the time of application,
- Indicate whether they dropped employer-sponsored dependent coverage within 4 months of making a SCHIP application.

The standardized application for children's medical benefits asks the insurance questions listed above that will assist with determining eligibility. The standard application for all benefits does not yet contain these questions. If the client completing this application is over the income standards for Medicaid but is within SCHIP income limits, the family is sent a request for additional information. If the family does not return the required information, they cannot be determined eligible for SCHIP.

To complete eligibility, information from the application is entered into the state's Automated Client Eligibility System (ACES), which automatically generates SCHIP eligibility notices and yearly reviews. ACES transfers information into the Medicaid Management Information System (MMIS). MMIS information is used to enroll clients into managed care health plans.

B. Explain how children are transferred between Medicaid and SCHIP when a child's eligibility status changes.

If a child becomes eligible for Medicaid due to a decrease in income, staff enter the income change in the Automated Client Eligibility System (ACES) and the case automatically and immediately, based on ACES deadline dates, changes to Medicaid. The change in ACES triggers a letter that is sent to the client informing them of the change. This process can occur at any time during the twelve-month SCHIP certification period.

If a family's income has increased at the time of the child's twelve-month recertification period, the information is reviewed by staff to determine eligibility. If income is within the SCHIP eligibility standards, the child is enrolled in SCHIP.

C. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.

Washington's SCHIP utilizes Washington's Medicaid managed care delivery system wherever practicable. This managed care system consists of contracts with health carriers for medical care coverage, contracts with Regional Support Networks for mental health care, and fee-for-service (FFS) for primary care case management (PCCM) clinics. Other Medicaid services are "carved out" of managed care and provided on a "wrap around" FFS basis. These include dental coverage, chemical dependency services, eyeglasses, hearing aid devices, pregnancy terminations, and non-emergent transportation.

SCHIP clients who are exempted from mandatory managed care enrollment and those who reside in a county where enrollment into managed care is optional utilize the same fee-for-service provider network as Medicaid clients.

Availability of practitioners

Managed care organizations (MCO's) must have a written access plan describing the mechanisms used to assure the availability of primary care providers (PCPs) and physician specialists, hospitals and pharmacies. Standards for the number and geographic distribution of PCPs and specialty care practitioners are established in the procurement requirements. MAA will request MCOs to submit their provider networks. MCOs must collect and analyze data to measure performance against these standards and implement corrective action when necessary.

As part of the procurement process, Healthy Options bidders are required to submit GeoNetwork analysis that describes how their network compares to MAA/Health Care Authority (HCA) access guidelines for distribution (travel distance) and capacity of primary care providers (PCPs), obstetrical providers, hospitals and pharmacies. This information is compared to the state's Basic Health (BH) and Public Employee Benefit Board (PEBB) networks to judge whether there is sufficient capacity. HO, BH and PEBB plans are required to submit monthly updates of provider network changes. MAA and HCA have an Integrated Provider Network Database (IPND) that allows the two agencies to conduct ongoing GeoNetwork analysis to ensure that there continues to be an adequate network during the contract period, and to assess whether there is a significant turnover of participating providers.

2.7 Cost Sharing:

A. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?

We will be able to collect data from the fall 2001 surveys of disenrolled and currently enrolled clients. We are also collecting data regarding the number of households who are 30, 60, 90 and 120 days behind on their premium payments. We anticipate that we will be able to report on this for our next annual report.

B. Has your State undertaken any assessment of the effects of cost-sharing on utilization of health service under SCHIP? If so, what have you found?

We do not have data yet on the effects of cost-sharing on utilization of health service. We anticipate that we will be able to report on this for our next annual report.

2.8 Assessment and Monitoring of Quality of Care:

A. What information is currently available on the quality of care received by SCHIP enrollees? Please summarize results.

The assessment of SCHIP enrollees' satisfaction with their health care and services is based on our work with the Consumer Assessment of Health Plans (CAHPS). We have conducted CAHPS surveys from 1997 through 2001. In 2001, we conducted our first CAHPS/SCHIP survey and produced a statewide report based on SCHIP client experience with their health care. These surveys were conducted in accordance with CAHPS Consortium (a group of national survey experts associated with the Harvard Medical School, RAND, and the Research Triangle Institute) protocols. The CAHPS survey measures clients' experiences with the health care and services received through the Medicaid Healthy Options (HO) program and fee-for-service (FFS) program The 1997 survey measured only the HO program. The 1998, 1999, and 2000 surveys included both HO enrollees and Medicaid FFS clients. The 2001 survey included SCHIP. To the extent possible, similar survey approaches will be used to assess SCHIP enrollees' satisfaction with care every other year, starting in 2002. The information from the 2001 SCHIP CAHPS survey is analyzed by our external quality review organization (EQRO).

B. What processes are you using to monitor and assess quality of care received by SCHIP enrollees, particularly with respect to well-baby care, well-child care, immunizations, mental health, substance abuse counseling and treatment and dental and vision care?

The quality and appropriateness of well child (birth through age 20) care, and age appropriate immunizations for SCHIP are addressed through the HO contract requirements for participating Managed Care Organizations (MCOs). Requirements for the SCHIP program are the same as those for the current HO and the fee-for-service (FFS) programs.

Washington State contracts only with MCOs regulated by the Office of the Insurance Commissioner (OIC), which regulates and monitors financial solvency and other consumer protection safeguards.

MAA monitors the quality and appropriateness of care of SCHIP enrollees through:

- Monitoring compliance with quality standards during annual on-site reviews;
- Evaluating compliance with Early Periodic Screening, Diagnosis and Treatment (EPSDT) requirements reported on annual focused reviews by an EQRO as required by federal law (Section 1902 (a)(30)(C) of the Social Security Act);
- Analysis of completed immunization rates reported on annual audited HEDIS reports;
- Client satisfaction/health status surveys for HO;
- Complaint management system;
- Exemption/disenrollment/fair hearing database;
- Standards for health plan internal quality improvement programs;
- Technical assistance;
- Corrective action requirements for less than acceptable performance;
- FFS encounter data reporting (form,format,periodicity) requirements the same as the HO program;
- Utilization controls for FFS that are consistent with all current utilization review requirements under the State Medicaid Plan. Examples of controls include external review of hospital claims data, exception-to-policy procedures, data audits, pre-authorization for extended coverage utilization, and drug utilization review;
- Requiring MCOs to maintain an internal program of quality assurance, as required by federal regulations (42 CFR 434.34); and
- Monitoring complaints and grievances at the level of the MCO and the Medicaid state agency.

C. What plans does your SCHIP program have for future monitoring/assessment of quality of care received by SCHIP enrollees? When will data be available?

SCHIP has the same rigorous oversight systems as the Healthy Options program. When appropriate, enrollee level information is available to resolve an individual SCHIP enrollee issue. In addition, MAA has contracted with its EQRO to conduct a statewide Client Satisfaction Survey with separate samples for children enrolled in SCHIP and Children requiring Chronic Care. The report will be available in December 2002.

SECTION 3. SUCCESSES AND BARRIERS

This section has been designed to allow you to report on successes in program design, planning, and implementation of your State plan, to identify barriers to program development and implementation, and to describe your approach to overcoming these barriers.

3.1 Please highlight successes and barriers you encountered during FFY 2001 in the following areas. Please report the approaches used to overcome barriers. Be as detailed and specific as possible.

Note: If there is nothing to highlight as a success or barrier, Please enter "NA" for not applicable.

A. Eligibility: Through an amendment that was approved in February 2001, we removed the requirement that a household must have a written signature of intent to pay premiums before the child's eligibility could be finalized for SCHIP. In the same amendment, we also removed the requirement that a child living in a county where enrollment into a managed care plan is mandatory be required to choose a managed care plan before eligibility could be finalized.

B. Outreach: Please refer to Section 2.4 for a complete summary of our successful outreach efforts.

C. Enrollment: We continue to meet our strategic goals regarding enrollment of SCHIP eligible children.

D. Retention/disenrollment: NA

E. Benefit structure: Washington's SCHIP provides comprehensive medical, dental and vision care for children, mirroring the benefits offered in our Medicaid program.

F. Cost-sharing: NA

G. Delivery system: NA

H. Coordination with other programs: NA

I. Crowd-out: NA

J. Other: We introduced an on-line application for medical benefits for both SCHIP and Medicaid applicants.

SECTION 4: PROGRAM FINANCING

This section has been designed to collect program costs and anticipated expenditures.

4.1 **Please complete Table 4.1 to provide your budget for FFY 2001, your current fiscal year budget, and FFY 2002-projected budget. Please describe in narrative any details of your planned use of funds.**

N*ote: Federal Fiscal Year 2001 starts 10/1/00 and ends 9/30/01).*

	Federal Fiscal Year 2001 costs	Federal Fiscal Year 2002	Federal Fiscal Year 2003
Benefit Costs			
Insurance payments			
Managed care	4,189,090	6,478,007	10,127,171
per member/per month rate X # of eligibles			
Fee for Service	4,283,890	6,472,067	6,826,473
Total Benefit Costs	8,472,980	12,950,074	16,953,644
(Offsetting beneficiary cost sharing payments)	(729,591)	(1,235,829)	(1,796,811)
Net Benefit Costs	7,743,389	11,714,245	15,156,832
Administration Costs			
Personnel	84,390	100,000	105,000
General administration	173,375	540,000	600,000
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing	1,983	3,000	3,500
Outreach/marketing costs	514,591	400,000	100,000
Other			
Total Administration Costs	774,339	1,043,000	808,500
10% Administrative Cost Ceiling	774,339	1,171,425	1,515,683
Federal Share (multiplied by enhanced FMAP rate)	5,578,260	8,325,378	10,377,466
State Share	2,939,468	4,431,867	5,587,866
TOTAL PROGRAM COSTS	8,517,728	12,757,245	15,965,332

4.2 Please identify the total State expenditures for family coverage during Federal fiscal year 2001.

The state of Washington does not offer family coverage through Title XXI.

4.3 What were the non-Federal sources of funds spent on your SCHIP program during FFY 2001?

__X__State appropriations
_____County/local funds
_____Employer contributions
_____Foundation grants
_____Private donations (such as United Way, sponsorship)
_____Other (specify)

A. Do you anticipate any changes in the sources of the non-Federal share of plan expenditures.

We do not anticipate any changes at this time.

SECTION 5: SCHIP PROGRAM AT-A-GLANCE

This section has been designed to give the reader of your annual report some context and a quick glimpse of your SCHIP program.

5.1 To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. If you do not have a particular policy in-place and would like to comment why, please do. (Please report on initial application process/rules)

Table 5.1	**Medicaid Expansion SCHIP program**	**Separate SCHIP program**
Program Name		CHIP
Provides presumptive eligibility for children	_____No _____Yes, for whom and how long?	__X__No _____Yes, for whom and how long?
Provides retroactive eligibility	_____No _____Yes, for whom and how long?	__X__No _____Yes, for whom and how long?
Makes eligibility determination	_____State Medicaid eligibility staff _____Contractor _____Community-based organizations _____Insurance agents _____MCO staff _____Other *(specify)*	__X__State Medicaid eligibility staff _____Contractor _____Community-based organizations _____Insurance agents _____MCO staff _____Other *(specify)*
Average length of stay on program	Specify months	Specify months N/A
Has joint application for Medicaid and SCHIP	_____No _____Yes	_____No __X__Yes
Has a mail-in application	_____No _____Yes	_____No __X__Yes
Can apply for program over phone	_____No _____Yes	_____No __X__Yes
Can apply for program over internet	_____No _____Yes	_____No __X__Yes
Requires face-to-face interview during initial application	_____No _____Yes	__X__No _____Yes
Requires child to be uninsured for a minimum amount of time prior to enrollment	_____No _____Yes, specify number of months What exemptions do you provide?	_____No __X__Yes, specify number of months 4 months What exemptions do you provide? 1. Parent lost job that covered children. 2. Parent with insurance died. 3. Child has a medical condition that, without treatment, could be life threatening or cause serious disability or loss of function. 4. Employer ended job-related dependent coverage.

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
		5. Dependent coverage terminated because the client reached the maximum lifetime coverage amount. 6. Coverage under a COBRA extension period expired. 7. Dependent coverage was not reasonably available (e.g., client has to travel to another city or state to get care for children). 8. Domestic violence led to the loss of this coverage. 9. The family's total out-of-pocket maximum for employer sponsored dependent coverage is fifty dollars per month or more.
Provides period of continuous coverage regardless of income changes	_____No _____ Yes, specify number of months Explain circumstances when a child would lose eligibility during the time period	_____No __X__Yes, specify number of months 12 months Explain circumstances when a child would lose eligibility during the time period • The family fails to pay SCHIP premiums for 4 consecutive months; • A SCHIP child becomes Medicaid eligible (e.g., change in family income or family size, or SCHIP child becomes pregnant); or • A child reaches their 19th birthday during the 12-month eligibility period.
Imposes premiums or enrollment fees	_____No _____Yes, how much? Who Can Pay? ___ Employer ___ Family ___ Absent parent ___ Private donations/sponsorship ___ Other (specify)	_____No __X__Yes, how much? • $10 per child, per month, with a family maximum of $30 per family. Families with 4 or more children pay a maximum of $30 per month; • American Indian/Alaska Natives (AI/AN) are excluded from cost sharing. Who Can Pay? ___ Employer _X_ Family _X_ Absent parent ___ Private donations/sponsorship ___ Other (specify) Premium statements are sent to the head of household. We have no sponsorship programs established at this time.
Imposes copayments or coinsurance	_____No _____Yes	_____No __X__Yes
Provides preprinted redetermination process	_____ No _____ Yes, we send out form to family with their information precompleted and: ___ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed	__X__ No _____ Yes, we send out form to family with their information and: ___ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed

5.2 Please explain how the redetermination process differs from the initial application process.

The redetermination process is similar to the initial application process. The client/head of household must complete an eligibility review form and mail it in for review of eligibility standards.

The eligibility review is mailed to the household approximately six weeks before the 12-month certification ends. Once the review is received and the child is determined eligible, they receive an additional twelve months of eligibility.

SECTION 6: INCOME ELIGIBILITY

This section is designed to capture income eligibility information for your SCHIP program.

6.1 As of September 30, 2001, what was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group? If the threshold varies by the child's age (or date of birth), then report each threshold for each age group separately. Please report the threshold after application of income disregards.

Title XIX Child Poverty-related Groups or Section 1931-whichever category is higher

Up to 200% of FPL for children under age 19
____% of FPL for children aged _____
____% of FPL for children aged _____

Medicaid SCHIP Expansion

____% of FPL for children aged _____
____% of FPL for children aged _____
____% of FPL for children aged _____

Separate SCHIP Program

Over 200% but less than 250% of FPL for children aged 0-19 years of age
____% of FPL for children aged _____
____% of FPL for children aged_____

6.2 As of September 30, 2001, what types and *amounts* of disregards and deductions does each program use to arrive at total countable income? *Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter "NA".*

Do rules differ for applicants and recipients (or between initial enrollment and redetermination)

____ Yes _X_ No

If yes, please report rules for applicants (initial enrollment).

Table 6.2			
	Title XIX Child Poverty-related Groups	Medicaid SCHIP Expansion	Separate SCHIP Program
Earnings	$ 90	$	$ 90
Self-employment expenses	$ Actual business expenses	$	$ Actual business expenses
Alimony payments Received	$ Actual amount	$	$ Actual amount
Paid	$ Court ordered amount	$	$ Court ordered amount
Child support payments Received	$ Actual amount	$	$ Actual amount
Paid	$ Court ordered amount	$	$ Court ordered amount
Child care expenses	$ Actual amount paid by household	$	$ Actual amount paid by Household
Medical care expenses	$ NA	$	$ NA
Gifts	$ Up to $30 is disregarded	$	$ Up to $30 is disregarded
Other types of disregards/deductions (specify)	$ NA	$	$ NA

6.3 For each program, do you use an asset test?

Title XIX Poverty-related Groups

X No___Yes, specify countable or allowable level of asset test_____

Medicaid SCHIP Expansion program

____No____Yes, specify countable or allowable level of asset test_____

Separate SCHIP program

X No____Yes, specify countable or allowable level of asset test_____

Other SCHIP program_____

___No____Yes, specify countable or allowable level of asset test_____

6.4 Have any of the eligibility rules changed since September 30, 2001?

___ Yes X No

SECTION 7: FUTURE PROGRAM CHANGES

This section has been designed to allow you to share recent or anticipated changes in your SCHIP program.

7.1 What changes have you made or are planning to make in your SCHIP program during FFY 2002 (10/1/01 through 9/30/02)? Please comment on why the changes are planned.

A. Family coverage
The State of Washington submitted an 1115 Waiver on November 5, 2001. As part of this waiver, we have proposed expanding coverage to parents of Medicaid and SCHIP children. Details on the waiver can be found at: http://maa.dshs.wa.gov/medwaiver/.

B. Employer sponsored insurance buy-in NC

C. 1115 waiver
Please see response to A. Family coverage

D. Eligibility including presumptive and continuous eligibility NC

E. Outreach NC

F. Enrollment/redetermination process NC

G. Contracting
In 2001, there were only three Managed Care Organizations (MCO's) serving SCHIP clients through a contracted health plan. We had allowed MCO's to submit bids on either Medicaid Healthy Options or SCHIP. In 2002, there will be seven MCO's providing care to SCHIP clients, as MCO's will be required to bid for both Medicaid Healthy Options and SCHIP.

H. Other
We will submit an amendment to our state plan to eliminate client co-pays. This will ensure more seamless coordination for clients who move between SCHIP and Medicaid as the delivery systems will be the same for both populations in 2002.